CITY OF AUBURN WASHINGTON

2014 – 2015 APPLICATION FOR UTILITY REBATE RATE EXEMPTIONS - ORDINANCE NO. 5361

Telephone: 253-931-3038 Fax: 253-876-1900
Mailing Address: 25 W Main St, Auburn WA 98001
Email: Utilities@AuburnWA.gov

Rebate Application must be received by May 31, 2014.

Mobile Home Park or Apartment Name: _____

Applicant Name: _____

(Must be name on lease or rental agreement)

Address: _____

Mailing Address (if different) _____

Phone Number: _____

Driver's License or ID Card: _____

The undersigned certifies, subject to the penalties of perjury, that:

1. The City Utility account is in his/her name, is living at the resident address listed below and is receiving water, sewer, storm, and/or garbage services.
2. The undersigned is a least ☐ 62 years of age OR ☐ is *permanently disabled.
   **Persons applying for the disability reduction for the first time must have their physician complete the form on the back of this application; subject to verification.*
3. There are (Qty.) ____adults (18 or older) and (Qty.) ____ children (17 or younger) living in the household.
4. Undersigned is **NOT** receiving additional utility allowances or rent subsidies from another governmental agency (HUD Section 8, King County Housing, etc.).
5. The **combined total gross income** from the undersigned and all individuals in the household from **January – December 2013** was $_____.

   Income Limits for 2013 Income:

1 Person	2 Persons	3 Persons	4 Persons	5 Persons
$30,900	$35,300	$39,700	$44,100	$47,650

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Date Received:		**Approved By:**	**Date:**
Received By:		**Denied By:**	**Date:**
Counted:	**Logged:**		

CITY OF AUBURN UTILITY DISCOUNT
2014/2015 APPLICATION FOR UTILITY RATE EXEMPTIONS
AFFIDAVIT FOR CLAIM OF DISABILITY - (FIRST TIME APPLICANTS ONLY)

The undersigned certifies, subject to the penalties of perjury, that the applicant meets the following criteria for receiving the exemption for utility services:

*"The applicant is **permanently disabled** in that the individual has lost both legs and arms or one leg and one arm, or total loss of eyesight, or is paralyzed or suffering from some other condition **permanently incapacitating** the applicant from ever performing any work at any gainful occupation."*

To be Completed by Physician Office: (Please Print)

Applicant

Name: _____

Address: _____
_____
_____

Telephone: _____

Physician

Business Name: _____

Business Address: _____
_____
_____

Business Telephone: _____

Print Name: _____

Signature: _____

Date: _____

Verification Required: Physician Office Stamp or Letter on office letterhead.